



Rural District of Droxford

ANNUAL REPORT

of the

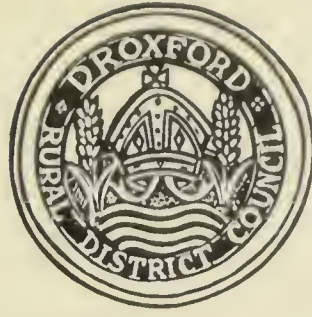
MEDICAL OFFICER of HEALTH

and

PUBLIC HEALTH INSPECTOR

FOR THE YEAR

1962



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DROXFORD RURAL DISTRICT COUNCIL

NORTHBROOK HOUSE,

BISHOP'S WALTHAM,

SOUTHAMPTON.

Tel. Bishop's Waltham 2241.

To The Chairman and Members
of the Droxford Rural District Council.

I have the honour to present the Annual Report for the year 1962 on the health and sanitary circumstances of the Rural District of Droxford. It is drafted in accordance with the requirements of the Ministry of Health.

The population showed an increase of 540 over the 1961 figure.

During the year under review, there was very little infectious disease.

In February 1962, oral poliomyelitis vaccine was first made available for routine immunisation of special groups as an alternative to the inactivated Salk vaccine.

The percentage of children under the age of one year, who were vaccinated against smallpox, was 56.5%.

There has been no case of diphtheria in the District during the past ten years.

Parents are again reminded that children should be immunised before their first birthday, the percentage of children, born in 1961 and immunised before the age of one year, was 69.2%.

The value of safety precautions on the prevention of accidents in the home, on the road and in the water is emphasised.

I should like to thank you all for your help and encouragement and I am grateful to the Officers of other Departments for their willing help and assistance at all times.

I also wish to record my grateful thanks to Mr. Lindley, the Chief Public Health Inspector, and to Mr. Wenden and Mr. Knowlton, for their valuable co-operation and assistance in compiling this report and to Mrs. Quiney for typing it.

S. Chalmers Perry

Medical Officer of Health
Droxford Rural District Council

LEGISLATION

OF PUBLIC HEALTH SIGNIFICANCE

Landlord and Tenant Act, 1962.

This Act requires the landlord of weekly tenancies to provide a rent book for the tenant.

National Assistance Act, 1948 (Amendment) Act, 1962.

This Act empowers local authorities to provide meals and recreation for old people.

Food Hygiene (General) Regulations, 1962.

These Regulations amend the Food Hygiene (General) Regulations, 1960 (which restricts the preparation and packing of food on domestic premises) by applying the regulation to the peeling of onions for the purposes of a food business.

Milk and Dairies (Emulsifiers and Stabilisers) Regulations, 1962. Emulsifiers and Stabilisers in Food Regulations, 1962.

These Regulations prescribe a list of permitted emulsifiers and stabilisers and prohibit the sale of food and milk containing emulsifiers and stabilisers not on the permitted list.

Oil Heater Regulations, 1962.

These Regulations impose requirements designed to reduce risk of death or injury.

Milk and Dairies (Preservatives) Regulations, 1962.

These Regulations prohibit the addition of any preservative to milk.

Preservatives in Food Regulations 1962.

These Regulations control the presence of preservatives in food.

Housing (Management of Houses in multiple occupation) Regulations, 1962.

Managers of any house let in lodgings or occupied by more than one family are required to ensure the good order, repair and cleanliness of the water supply, drainage, lighting and heating, ventilation, disposal of refuse, means of escape in case of fire, common rooms and passages.

These Regulations prescribe a code of management which Local Authorities may apply by order to any such house, which is in an unsatisfactory condition in consequence of defective management.

STATISTICS OF THE AREA

Area	62,845 acres
"Home"Population (mid-1962)	23,300
Number of Hereditaments (31/3/63).....	7,577
Rateable Value (31/12/62)	£258,289
Sum represented by a penny rate (31/3/62)	£970. 16s. 0d.

NATURAL AND SOCIAL CONDITIONS OF THE AREA

The Rural District is situated in the south-east corner of Hampshire. The northern half lies on the chalk uplands and the remainder on the sands and clays of the Hampshire Basin. The former do not reach any great height, only rarely exceeding 600 feet, but they provide attractive scenery and a National Nature Reserve has been established at Old Winchester Hill.

The principal watercourse is the Meon, a chalk stream, and the only other rivers are the headwaters of two tertiary streams, the Hamble in the south-west and the Wallington in the south-east.

The differentiation in soils is reflected in land use; on the chalk there is arable farming with units of comparatively large acreage, on the tertiary formation there are small dairy farms on the clay, and extensive smallholdings, with strawberry growing a speciality of the district, on the loams and sands.

For planning purposes, the central and southern parts lie within the proposed Green Belt and the northern part is included in a designated area of outstanding natural beauty.

Cottages in the old world villages of the Meon Valley are much sought after and in certain other villages scheduled for limited expansion, considerable building development has taken place in recent years.

VITAL STATISTICS

Births

	1961			1962		
	M.	F.	Total	M.	F.	Total
Live Births (Legitimate)	186	165	351	192	183	375
(Illegitimate)	11	8	19	12	8	20
	---	---	---	---	---	---
Total Live Births	...	...	370	...	...	395

Live Birth Rate per 1,000 of the estimated population (mid-1962) was 16.95 compared with 18.0 for the whole of England and Wales. Illegitimate live births per cent of total live births was 5.1%.

	1961			1962		
	M.	F.	Total	M.	F.	Total
Still Births (Legitimate)	3	2	5	2	4	6
(Illegitimate)	1	-	1	-	-	-
	<hr/>	<hr/>	<hr/>	<hr/>	<hr/>	<hr/>
Total Still Births	...	...	6	...	...	6

Still Birth Rate per 1,000 total (live and still) births was 15.0 compared with 18.1 for the whole of England and Wales.

Deaths

	1961			1962		
	M.	F.	Total	M.	F.	Total
From all causes	137	171	308	154	169	323

Death Rate per 1,000 estimated population was 13.8 compared with 11.9 for the whole of England and Wales.

Maternal Mortality

	1961	1962
Pregnancy, Childbirth, Abortion	Nil	Nil

Maternal Mortality Rate per 1,000 total (live and still) births, Nil.

Infant Mortality (deaths under one year)

	1961			1962		
	M.	F.	Total	M.	F.	Total
Legitimate	3	-	3	3	3	6
Illegitimate	<hr/>	<hr/>	<hr/>	<hr/>	<hr/>	<hr/>
Total Infant Deaths	...	...	3	...	...	6

Infant Mortality Rate per 1,000 live births was 15.2 compared with 21.6 for the whole of England and Wales.

The rate for each calendar year is not regarded as a reliable guide, for the number of births in the District is insufficient to be of significance statistically.

But, if this rate is taken over a period of five years, it may then be considered reasonably reliable and one of the best indices of the social circumstances of the district. High rates are commonly associated with overcrowding and defective sanitation.

It is therefore satisfactory to report that, during the past fifteen years, the quinquennial rates for this district have been consistently lower than the figures for the country as a whole.

The following table shows the rate for the district as compared with the rate for England and Wales, each over a five-year period.

INFANT MORTALITY RATE (per 1,000 live births)		
Year	Droxford Rural District	England and Wales
1946	28.5	42.0
1947	28.5	39.2
1948	26.3	35.9
1949	25.5	33.3
1950	23.7	30.6
1951	19.4	29.2
1952	15.0	27.8
1953	12.9	26.8
1954	12.1	25.76
1955	10.6	24.9
1956	12.28	23.9
1957	11.15	23.3
1958	15.2	22.6
1959	14.59	22.18
1960	16.0	21.88

Causes of Death

	Male	Female	Total
1. Tuberculosis of Respiratory System	3	-	3
2. Other forms of Tuberculosis	-	-	-
3. Syphilis	1	1	2
4. Diphtheria	-	-	-
5. Whooping Cough	-	-	-
6. Meningococcal Infections	-	-	-
7. Acute Poliomyelitis	-	-	-
8. Measles	-	-	-
9. Other Infective and Parasitic Diseases.	1	-	1
10. Malignant Neoplasm, Stomach.....	2	2	4
11. " " Lung, Bronchus	13	1	14
12. " " Breast	-	6	6
13. " " Uterus	-	4	4
14. Other Malignant and Lymphatic Neoplasms	12	7	19
15. Leukaemia, Aleukaemia	1	2	3
16. Diabetes	1	4	5
17. Vascular Lesions of Nervous System	23	20	43
18. Coronary Disease, Angina	25	19	44
19. Hypertension with Heart Disease	1	5	6
20. Other Heart Disease	17	44	61
21. Other Circulatory Disease	8	7	15
22. Influenza	3	3	6
23. Pneumonia	19	20	39
24. Bronchitis	5	3	8
25. Other Diseases of Respiratory System ..	3	1	4
26. Ulcer of Stomach and Duodenum	1	1	2
27. Gastritis, Enteritis and Diarrhoea	1	-	1
28. Nephritis and Nephrosis	-	-	-
29. Hyperplasia of Prostate	1	-	1
30. Pregnancy, Childbirth, Abortion	-	-	-
31. Congenital Malformations	-	1	1
32. Other Defined and Ill-defined Diseases.	12	17	29
33. Motor Vehicle Accidents	1	-	1
34. All other Accidents	-	1	1
35. Suicide	-	-	-
36. Homicide and Operations of War	-	-	-
	<hr/> 154	<hr/> 169	<hr/> 323

GENERAL PROVISIONS OF HEALTH SERVICES
FOR THE AREA

Public Health Officers of the Authority

Medical Officer of Health:

S. CHALMERS PARRY, M.A., CANTAB., M.R.C.S., L.R.C.P., D.P.H.,

Engineer, Surveyor and Chief Public Health Inspector:

F. LINDLEY, M.R.S.H., A.M.I.S.E., M.P.H.I.A.,

Additional Public Health Inspectors:

H.L. WENDEN, CERT. S.I.B.,

L.N. CRADDOCK, CERT. S.I.B., A.R.S.H., M.P.H.I.A.,

Administrative Assistant:

D. KNOWLTON, A.C.C.S.

Laboratory Facilities

Bacteriological work is carried out by the Public Health Laboratory, at the Royal Hampshire County Hospital, Winchester (Telephone, Winchester 3807) and specimens of clinical materials (sputum, swabs, etc.,) and samples of water, milk and foodstuffs are sent for bacteriological examination to the Director, Dr. M.H. Hughes.

Specimens may be deposited in the sample box placed outside the Laboratory, or they may be left at the Main Hall of the Hospital at any time when the Laboratory is closed. At weekends, and on public holidays, arrangements are made for dealing with specimens during the morning and evening. Urgent specimens can be dealt with at any time and Dr. M.H. Hughes is available at Twyford 3349 for telephone consultations when he is not in the Laboratory.

Some specimens in connection with cases of infectious diseases, which have been admitted to Priorsdean Hospital, are sent for bacteriological examination to Dr. K. Hughes, Director of the Public Health Laboratory, Milton, Portsmouth, (Telephone, Portsmouth 22331).

At Portsmouth, specimens may be left at the Porter's Lodge of the Infectious Diseases Hospital, at any time. Urgent specimens can be dealt with, when the Laboratory is closed, by telephoning the technician on call at St. Mary's Hospital (Portsmouth 22331).

Samples for chemical analysis are sent to the Public Analyst at "Spetchley", Cobden Avenue, Bitterne Park, Southampton (Telephone, Southampton 55826).

Ambulance Facilities

All applications for the use of ambulances should be directed to the Ambulance Officer, Fareham (Telephone, Fareham 2170) who arranges for the most conveniently situated ambulance to attend.

Hospital Car Service

The use of this service may be obtained through the Ambulance Officer (Telephone, Fareham 3626).

Smallpox cases (suspected or confirmed) requiring transport to hospital will be conveyed by the County Ambulance Service to Weyhill Hospital, Andover. Requests for admission should be made to the Winchester Group Hospital Management Committee (Telephone, Winchester 5151).

Nursing and Health Visiting in the Homes and Clinics

The names and addresses of District Nurses, Midwives and Health Visitors, who practise in the district under the direction of the County Medical Officer, are shown in the following table:-

Names and Addresses of Nurses	District Served (excluding Group Practice)	Names of Health Visitors
MISS J. WARBURTON, S.R.N., S.C.M. 18 Penfords Paddock, Bishop's Waltham. (Tel: Bishop's Waltham 2699)	Swanmore Waltham Chase Part of Bishop's Waltham.	MISS B.M. WATSON S.R.N., S.C.M., R.S.H. Cert. Tel: Bishop's Waltham 2607
MISS A.M. HOBBS, S.R.N., S.C.M. 14 Folly Field, R.M.N., Bishop's Waltham. (Tel: Bishop's Waltham 2330)	Durley, Upham Part of Bishop's Waltham.	
MRS. M.S. WILLS, S.R.N., S.C.M. Hillboro, Hoads Hill, Wickham. (Tel: Wickham 2277)	Shedfield (except Waltham Chase) Wickham Boarhunt.	
MRS. E.W. GOODSIR, S.R.N., 11 Ashling Close, S.C.M. Denmead. (Telephone: Hambledon 444)	Southwick and Widley.	
MRS. E.R. PORTER, S.R.N., S.C.M. 2 Bere Road, Denmead. (Telephone: Hambledon 649)	Denmead Hambledon	
20 The Park, Droxford. (Tel: Droxford 210)	Soberton Droxford Corhampton Meonstoke Exton	
	Warnford West Meon	MISS D.V. ALLOWAY S.R.N., Q.N. R.S.H. Cert. Tel: Horndean 2478
MISS CAMPBELL, S.R.N., S.C.M. Leehurst, Botley. (Tel: Botley 2015)	Curdridge Curbridge area of Wickham	MISS BYATT, S.R.N., S.C.M. R.S.H. Cert. Tel: Botley 2289)

The names of District Nurses, Midwives and Health Visitors who are attached to Group Practices in the district are shown in the following table:-

Names and Addresses of Nurses and Midwives	Group Practice	Names of Health Visitors
MISS E.M. MAY, S.R.N.,S.C.M., Q.N., R.S.H. Cert. 16 Glenthorne Meadow, East Meon. (Tel: East Meon 263)	Dr. M.P. Creedy- Smith	MISS E.M. MAY, S.R.N.,S.C.M., Q.N. R.S.H. Cert. Tel: East Meon 263
	Dr. T.H.B. Urmston Dr. D.S. Watson	MISS P. JENKINS S.R.N.,S.C.M., R.S.H. Cert. Tel: Twyford 2021.
	Dr. J.D. Kinnear Dr. W.T.S. Moore	MISS B.G.M. OSBORN S.R.N.,S.C.M., R.S.H. Cert. Orthopaedic Nursing Cert. Tel: Portsmouth 31155

Child Welfare Centres

The following Child Welfare Centres in the Rural District are open for children under five years of age.

Centre	Hall	Afternoons
Bishop's Waltham	The Institute	1st and 3rd Fridays
Denmead	Memorial Hall, Main St.	4th Mondays
Droxford	Community Hall	1st Mondays
Durley	Memorial Hall	2nd Fridays
Hambledon	Women's Institute	2nd Mondays
Meonstoke	The Meon Hut	1st Tuesdays
Southwick	Manor Hall	4th Fridays
Swanmore	Parish Hall	3rd Thursdays
Upham	Village Hall	3rd Tuesdays
Waltham Chase	Chase Hut	2nd and 4th Wednesdays
West Meon	Queen Victoria Institute	2nd Mondays
Wickham	Victory Hall	1st and 3rd Wednesdays

The following five Centres, situate in adjoining districts, are available for children living near the boundaries of the district:-

Centre	Hall	Afternoons
East Meon	Institute Hall	1st and 3rd Thursdays
Fair Oak	Women's Hall	2nd and 4th Thursdays
Park Gate	British Legion Hall	2nd and 4th Thursdays
Purbrook	Deverell Hall	2nd and 4th Wednesdays
Titchfield	Parish Hall	1st and 3rd Mondays

The work of the voluntary helpers, who assist the Medical and Nursing staff at the Welfare Centres, is greatly appreciated.

FAMILY PLANNING ASSOCIATION CLINICS

Advice on family planning is given at the following clinics, which are run on a voluntary basis, as the Service is not available under the National Health Service.

A lady doctor and sister are in attendance.

AREA	ADDRESS OF CLINIC	DAY	TIME
Cosham	Child Welfare Clinic, Northern Road	Wednesdays	1.30-3.30p.m.
Eastleigh	The Red House, 6 Romsey Road	Fridays	1.30-3.30p.m.
Fareham	County Council Health Clinic, Assembly Hall, West Street	Mondays	5.0-7.0p.m. New patients by appointment
Gosport	War Memorial Hospital, Casualty Dept. Bury Road	Thursdays	6.0-7.30p.m.
Portsmouth	Trafalgar Place, Clive Road, Fratton	Tuesdays Fridays	1.30-3.30p.m. 6.0-8.0p.m.
Winchester	The Hut (adjoining Trafalgar House) Trafalgar Street	Tuesdays	2.0-4.0p.m.
Havant	County Council Health Clinic, Parkway	Thursdays	6.0-8.0p.m.

Any further information can be obtained from the County Medical Officer.

It is desirable that a woman should, at her first attendance, take to the Clinic a letter from her own doctor.

* Tuberculosis

The following Chest Clinics are available to patients suffering from Tuberculosis:

FAREHAM - The Chest Clinic, St. Christopher's Hospital, Wickham Road,

Telephone: Fareham 2263.

Wednesday 9.45a.m. Old Patients.
1.45p.m. New Patients.
Evening Clinic (2nd Wed. in month only)

Thursday 9.45a.m. Old Patients.
2.00p.m. New Patients.

Chest Physician - Dr. Joan Butterworth

HAVANT - The Chest Clinic, Queen Alexandra Hospital, Portsmouth.

Telephone: Cosham 79451. Extension 114.

Monday 9.30a.m. - 12.30p.m. Old Patients.
1.30p.m. - 5.00p.m. Old Patients.

Wednesday 2.00p.m. Skin testing

Thursday 2.00p.m. - 5.00p.m. New Patients.

Chest Physician - Dr. J.P. Sharp

WINCHESTER - The Chest Clinic, Royal Hampshire County Hospital.

Telephone: Winchester 5151. Extension 347.

Wednesday 10.00a.m. - 12.30p.m. Old Patients.
2.00p.m. - 4.30p.m. New Patients.

Thursday 10.00a.m. - 12.30p.m.

Chest Physician - Dr. A. Capes

EASTLEIGH - The Mount Hospital, Bishopstoke.

Telephone: Eastleigh 2335.

Tuesday 2.00p.m. - 5.00p.m. All Patients.

Wednesday 9.00a.m. - 12 Noon. All patients.
2.00p.m. - 5.00p.m. All Patients.

Friday 2.00p.m. 1st only - BCG for children

Chest Physician - Dr. D.C. Lillie

* Venereal Diseases

Treatment is available at the following Clinics:

PORTSMOUTH - St. Mary's Hospital.

Males: 10a.m. to 12 Noon and 5p.m. to 7p.m.
Tuesdays and Thursdays.
10a.m. to 12 Noon Saturdays.

Females: 5p.m. to 7p.m. Mondays.
2p.m. to 4p.m. Wednesdays.
10a.m. to 12 Noon Fridays.

SOUTHAMPTON - 44 Bullar Street.

Males: 9a.m. to 12 Noon Monday to Saturday.
5p.m. to 7p.m. Monday to Friday.

SOUTHAMPTON - 46 Bullar Street (opposite Chest Clinic).

Females: 12 Noon to 1p.m. Mondays.
2p.m. to 7p.m. Tuesdays.
3p.m. to 7p.m. Thursdays.
2p.m. to 4p.m. Fridays.

WINCHESTER - The Royal Hampshire County Hospital, Out-Patients Annexe.

Males: 10.30a.m. to 12 Noon Saturdays.

Females 2p.m. to 4p.m. Mondays.

SCHOOL HEALTH SERVICES

*Orthopaedic Clinics

Orthopaedic cases, requiring treatment, are seen by appointment from the Appointments Officer at each Hospital, at the following Clinics:-

<u>Alton</u>	<u>Surgeon's Clinic</u> , held at Lord Mayor Treloar Hospital on Fridays. <u>Remedial Clinic</u> , held at Lord Mayor Treloar Hospital daily.
<u>Winchester</u>	<u>Surgeon's Clinic</u> , held at the Royal Hampshire County Hospital, 1st Friday each month p.m. <u>Remedial Clinic</u> , held at the Royal Hampshire County Hospital, daily.
<u>Fareham</u>	<u>Minor Clinic</u> , held at the County Health Clinic, West Street, as required, by appointment with the County Medical Officer. <u>Remedial Clinic</u> , held at St. Christopher's Hospital, on Mondays and Thursdays all day.
<u>Gosport</u>	<u>Surgeon's Clinic</u> , held at Gosport War Memorial Hospital, Bury Road, Gosport, on Tuesdays p.m. <u>Remedial Clinic</u> , held at The Gobles Health Clinic, Spring Garden Lane, Gosport, on Fridays.
<u>Havant</u>	<u>Surgeon's Clinic</u> , held at Havant War Memorial Hospital, on 4th Tuesday, p.m. <u>Remedial Clinic</u> , held at Health Clinic, 4 Park Way, on Tuesdays, all day (except 4th Tuesday p.m.) and Wednesdays all day.
<u>Petersfield</u>	<u>Remedial Clinic</u> , held at Petersfield General Hospital as required.

*Ear, Nose and Throat Clinics

Cases, referred for specialist advice, are examined at Portsmouth Eye and Ear Hospital, or the Royal Hampshire County Hospital, Winchester, and the treatment is carried out there or at Petersfield.

*Orthoptic Clinics

Cases, selected by the School Oculist, are referred to the Eye and Ear Hospital, Portsmouth, or from the Winchester Ophthalmic Clinic to the Royal Hampshire County Hospital, Winchester.

*Ophthalmic Clinics

These are available, by appointment, through the County Medical Officer, at the following places:-

<u>Winchester</u>	Held at Trafalgar House - 1st and 4th Mondays, all day.
<u>Havant</u>	Held at County Council Clinic, Park Way - every Monday a.m. only.
<u>Fareham</u>	Held at St. Christopher's Hospital - every Tuesday a.m. only.
<u>Petersfield</u>	Held at County Council Health Clinic, Love Lane - 2nd Tuesday p.m. only and 2nd and 4th Thursdays a.m. only.

Speech Therapy Clinics

Cases attend, by appointment, at the following centres:-

<u>Winchester</u>	Health Clinic, Trafalgar House, every Monday p.m. and Wednesday and Friday all day.
<u>Fareham</u>	Health Clinic, The Assembly Hall, every Monday at 9.30a.m. and Thursday at 9.30a.m. and 1.30p.m.
<u>Havant</u>	County Council Health Clinics, Park Way, Havant and Dunsbury Way, Leigh Park, all day, Monday to Friday of each week.

Child Guidance Clinic

Cases are seen, by appointment, at Trafalgar House, Winchester.

Dental Clinics

These are held, when required, for school children, pre-school children and expectant and nursing mothers, by appointment at:-

County Council Health Clinic, Love Lane, Petersfield,
(Telephone, Petersfield 954, between 9a.m. and 9.15a.m. for
appointments)

County Council Health Clinic, Park Way, Havant,
(Telephone, Havant 716)

County Council Health Clinic, The Assembly Hall, off West Street,
Fareham, (Telephone, Fareham 2937.)

(Continued)

Dental Clinics (continued)

Dental Clinic, County Primary School, Stakes Road, Waterloooville
(Telephone, Waterloooville 2022).

4 The Square, Winchester
(Telephone, Winchester 3347)

Dental Clinic, Chamberlayne Road, Eastleigh
(Telephone, Eastleigh 2498)

The Manor School. Portchester
(Telephone, Cosham 76441)

Also at other premises and schools as and when required.

* These services are the responsibility of the Regional Hospital Board.

List of Clinics most accessible to each Parish

PARISHES	Child Welfare	Chest	Orthopaedic	Ear, Nose and Throat	Eye	Speech	Dental
Bishop's Waltham	Bishop's Waltham	Fareham	Winchester Fareham Gosport	Winchester	Winchester Fareham	Winchester Fareham	Winchester Fareham
Boarhunt	Southwick Wickham	Fareham	Fareham	Portsmouth	Fareham	Fareham	Fareham
Corhampton & Meonstoke	Meonstoke	Fareham	Petersfield Fareham Gosport	Portsmouth	Petersfield Fareham	Petersfield	Petersfield Fareham
Curridige	Waltham Chase	Fareham	Fareham Gosport	Winchester	Fareham	Fareham	Eastleigh
Denmead	Denmead	Cosham	Havant	Portsmouth	Havant	Havant	Waterlooville
Droxford Soder-ton	Droxford	Fareham	Fareham Gosport	Portsmouth	Fareham	Fareham	Fareham
Durley	Durley	Eastleigh	Eastleigh	Winchester	Winchester	Winchester	Eastleigh
Exton	Meonstoke	Fareham	Petersfield Fareham Gosport	Winchester Portsmouth	Petersfield Fareham	Petersfield	Petersfield Fareham
Hambledon	Hambledon	Cosham	Havant	Portsmouth	Havant	Havant	Waterlooville
Shedfield	Waltham Chase	Fareham	Fareham Gosport	Winchester Portsmouth	Fareham	Fareham	Fareham
Southwick & Widley	Southwick	Fareham Cosham	Fareham Gosport	Portsmouth	Fareham	Fareham	Fareham Portchester
Swanmore	Swanmore	Fareham	Fareham Gosport	Winchester	Fareham	Fareham	Fareham
Upham	Bishop's Waltham Upham	Winchester	Winchester	Winchester	Winchester	Winchester	Eastleigh
Warrford West Meon	Meonstoke West Meon East Meon	Winchester	Petersfield	Winchester	Petersfield	Petersfield	Petersfield
Wickham	Wickham Titchfield Park Gate	Fareham	Fareham Gosport	Portsmouth	Fareham	Fareham	Fareham

HOSPITALS

General

There are no General Hospitals within the district, but the following hospitals are available:-

THE ROYAL SOUTH HANTS HOSPITAL, SOUTHAMPTON
(Telephone, Southampton 26211)

CHILDREN'S HOSPITAL, SOUTHAMPTON
(Telephone, Southampton 71012)

THE ROYAL HAMPSHIRE COUNTY HOSPITAL, WINCHESTER
(Telephone, Winchester 5151)

THE ROYAL PORTSMOUTH HOSPITAL, PORTSMOUTH
(Telephone, Portsmouth 22281)

ST. MARY'S HOSPITAL, PORTSMOUTH
(Telephone, Portsmouth 22331)

Knowle Hospital (Wickham 2271) situated at Knowle, in the Parish of Wickham is administered by the Regional Hospital Board, Portsmouth.

Infectious Diseases

There is no infectious diseases hospital in the district.

Any Infectious Diseases Hospital is available for the admission of cases occurring in the district. Patients are generally admitted to the Priorsdean Infectious Diseases Hospital, Milton Road, Portsmouth (Telephone, Portsmouth 22331) or to the Victoria Isolation Hospital, Morn Hill, Winchester (Telephone, Winchester 2048) or Southampton Chest Hospital, (Pavilion "A"), Oakley Road, Southampton (Telephone, Southampton 71042) which are under the control of the Regional Hospital Board.

Special arrangements have been made for the admission of children suffering from acute poliomyelitis to the Lord Mayor Treloar Hospital, Alton, (Telephone, Alton 2811).

Sanatoria

Sanatoria for patients, suffering from Tuberculosis, are provided by the Regional Hospital Board.

Smallpox

The Regional Hospital Board makes provision for the treatment of cases of smallpox at Weyhill Hospital, Andover. The Winchester Group Hospital Management Committee (Telephone, Winchester 5151) deals with requests for admission of these patients.

P R E V E N T I V E M E A S U R E S

FOOD HYGIENE

Personal Hygiene

In normal circumstances, we all wash our hands with soap and hot water before handling food and immediately after using the toilet. This practice is absolutely essential for everybody, for toilet paper is porous; and, once contaminated, the hands will leave bacteria behind on everything they touch. Licking the fingers or touching the hair, lips or nose or a soiled handkerchief cancels the benefit of a previous wash. Short nails are more easily kept clean. "No touch" technique should be practised whenever possible; where handling is an essential process, germicidal creams, applied after careful hand washing, have been found effective.

Precautions

It should constantly be borne in mind by all concerned in the handling, preparation and storage of food - particularly by those who work in canteens or who serve food to large numbers - that the utmost care must be taken to obviate the risk of food poisoning, which may occur even in the best equipped canteens.

Any food handler should report to his employers:-

- (1) Diarrhoea or vomiting.
- (2) Septic cuts or sores, boils or whitlows.
- (3) Discharges from the ear, eye or nose.
- (4) Typhoid fever, paratyphoid fever or any other salmonella infection, dysentery or any staphylococcal infection likely to cause food poisoning or being a "carrier" or any of these illnesses.

Housewives and foodhandlers should cover, with a waterproof dressing, any exposed sore or wound they have - particularly on their hands and arms - as infections are quickly spread in this way. For a finger wound, a rubber fingerstall is a safeguard while food is being handled.

Customers have now become more clean food minded and are more inclined to complain to the management when they notice any obvious unhygienic practices.

The hygiene standard of these shops and restaurants therefore lies to some extent in housewives' hands.

A high standard of hygiene is a benefit to food traders, for it attracts business; and it is of course all in the interest of the general public to encourage safer practices.

Cakes, boiled sweets, cooked food and vulnerable foods should be handled by tongs or servers and not fingered by the hands, for they are never clean enough safely to handle food of this nature.

Protection

Vulnerable foods - which include pressed meat, brawn, meat pies, stews, trifles, custards and synthetic cream - are normally quite safe when prepared, but they act as ideal breeding grounds for any dangerous germs that gain access, and, if kept at warm temperature, the germs will multiply very rapidly.

Made up meat dishes and other vulnerable foods provide a perfect medium for the growth and multiplication of bacteria.

Special care and attention is needed in the selection, the handling and the storage of food in summer because bacteria multiply more quickly in warm weather - and the harmful ones cause food poisoning. Most of the family outbreaks happen in the summer time.

The ordinary group of food poisoning organisms (i.e. the Salmonellae) are killed at high temperatures, but the fact that a product is to be heat-treated is no absolute safeguard against any spread - as the infection is often carried from the raw material on the hands and utensils to some article of food in the same premises, which is either already cooked or not subject to heat treatment.

Prevention

There is, however, another type of germ that is not killed by heat and it does not require the presence of air for it to produce its toxins; so, as long as the temperature conditions are suitable and the intervals of time between the end of cooking and the consumption of food are sufficiently long for the organism to survive and breed, there is always a possibility of its giving rise to food poisoning.

This organism (Cl. Welchii) is not uncommonly found in meat, so the sooner meat is eaten after cooking, the less likelihood there is for cases of food poisoning from this source of infection to occur. As this organism is fairly widespread in nature, methods of prevention must be concentrated far more on care over cooking and storage. Statistics emphasise the importance of ensuring that the organisms in the meat - and particularly the heat resistant spores that have survived cooking - are given no opportunity to incubate. Cutting and other manipulation of meat in the raw state must be reduced to a minimum; and, if meat is to be minced, this should be done with as short an interval as possible before cooking.

As a general rule, meat - whether as cuts or in pies or stews - should be thoroughly cooked and eaten hot; if this is impossible, it should be cooled rapidly within 1½ hours of cooking and refrigerated until required. In any event, there should be the shortest possible time between cooking and eating in order to limit the number of organisms; for it is only when they have been allowed to multiply that trouble will occur.

The size of cuts is of some importance from the public health point of view; for the rate of penetration and loss of heat is proportional to the size of the joint. Meat, sliced after cooking, should be kept cold.

For minces, meat should be minced when raw and eaten freshly cooked; stockpots are a hazard, and the same chopping board should not be used for both raw and cooked meat.

Re-handled and re-heated meat is still the main villain of the piece. In fact, in 1961, two thirds of the outbreaks, traced to a specific cause, were associated with cold meats which had been re-handled, made-up meats (such as meat pies) and re-heated dishes (such as stews and shepherd's pie).

Soups, stews, gravies, pies, pease-pudding, etc., provide even better conditions for the multiplication of the germs than solid meat. Gravy should never be re-heated; soup and stock, if re-heated, must be boiled.

Pressure cooking must be considered one of the safest measures against the survival of spores.

But emphasis should rightly be placed on methods of preventing the food from becoming contaminated in the first place.

Undercooking

Apart from bacterial and toxin poisoning, which can be conveyed by undercooked food, there is the additional danger of worms and flukes being transmitted to man by eating infected meat, fish, shellfish or watercress.

Infected pork and pork products, when insufficiently cooked, can cause human infection with tapeworm or trichinosis; and undercooked beef, infected with tapeworm, can cause tapeworm in man.

Fluke disease, which is a serious disease in man, can be transmitted to him by eating infected watercress. In the prevention of this disease, housewives are warned not to buy watercress from casual sources and are advised to buy only from accredited traders.

Cattle should be kept right away from watercress beds and from streams passing through their pasture land.

Cooking and Refrigeration

Many outbreaks of bacterial food poisoning would never have occurred if the food, after being cooked, had been rapidly cooled and then placed in a refrigerator until actually required, instead of being left at room temperature overnight and then eaten cold, or warmed up the next day. Food poisoning organisms will multiply and produce food poisoning only if food is kept under certain temperature and moisture conditions over a period of time.

If meat is cooked and allowed to cool slowly in a warm or humid kitchen, or in a warm oven where it has been cooked, any germs, deposited on it from the hands, increase rapidly. Even warming it up later in a stew or mince may not be sufficient to kill off harmful bacteria. All food should be thoroughly cooked and, if not required for immediate consumption, rapidly cooled.

A well ventilated larder or suitably sited safe, preferably with a through-draught or fan, helps good and efficient cooling. A marble slab is invaluable for the cool shelf in a larder and, even here, the food must be carefully protected against flies.

As soon as it is cooled, meat can be placed in an icebox, or, better still, in a refrigerator, if available.

Refrigerators were frequently regarded as luxuries; but people are now more "refrigerator-minded" although often unaware of the important role it plays in the prevention of food poisoning.

The three groups of bacteria - Salmonella, Staphylococcus and Clostridium Welchii - cause food poisoning only after growth and multiplication in the food.

Growth is prevented only at a refrigeration temperature of 4°C. or below.

Where cold rooms are not available, the hot meat should be left in a cool draughty place for 1½ hours before storage in the domestic type of refrigerator.

Refrigeration conserves food in a wholesome and palatable condition and definitely retards the growth of bacteria, if they are present. It is, therefore, most important that vulnerable foods such as gravy, soup, stock, custard and cake fillings, on which food poisoning bacteria can increase easily, should be stored at a low temperature in a refrigerator or a cool larder to prevent the germs from multiplying.

It is not generally appreciated that the germs which commonly cause food poisoning do not necessarily alter the smell, taste or appearance of the food.

Practice

The Chief Medical Officer to the Ministry of Health has stated:-

"The remedy is largely in the hands of caterers. Nowadays there is little excuse for unhygienic practice in the preparation and serving of food; the risks are well known and the simple methods by which they may be avoided are within the reach of all. That they are not practised is a direct reflection upon the management responsible."

A high standard of hygiene for food traders is best obtained by observing the following simple rules:-

- (1) Protection of food from all sources of contamination (dust and droplet infection as well as from flies, cockroaches, rats and mice)
- (2) Personal cleanliness of "food non-handlers"
- (3) Proper storage and display of food at a safe temperature.

A recent report from the Public Health Laboratory Service on Food Poisoning in England and Wales, states: "Good hygiene and the exclusion from food handling of persons with septic lesions on the skin will not by themselves ensure the safety of such frequently implicated foods as brawn, pressed meats, ham and bacon, the additional measure is refrigeration."

As a regular customer, the housewife can, however, influence traders by making it clear that she only chooses those who take special care to ensure the freshness and cleanliness and good storage of foods which they sell.

Protection of the public and family lies in personal hygiene, kitchen hygiene and the good management of the buying, storing, cooking and cooling of the food.

Routine inspection of food premises is proceeding and any complaints received by this department are thoroughly investigated.

In this connection, the Health Department would be glad to receive from the general public complaints of unhygienic methods practised in any food shops.

Food Poisoning Statistics 1952 - 61
(Public Health Laboratory Service)

Year	General Outbreaks	Family Outbreaks	Sporadic Cases	Total Incidents
1952	372	340	2,807	3,519
1953	492	422	4,363	5,277
1954	506	630	4,880	6,016
1955	612	723	7,626	8,961
1956	563	616	6,534	7,713
1957	473	501	6,097	7,071
1958	285	601	6,414	7,300
1959	295	666	6,885	6,428
1960	262	616	5,550	6,428
1961	229	490	4,668	5,387

Throughout the whole of the past decade, the most striking feature has been the enormous number of "sporadic" cases isolated. (For every recorded outbreak involving 20 or more persons there were approximately 50 isolated or familial infections).

Figures in the above table clearly show that, although the general outbreaks of food poisoning that occur in schools, canteens, hotels and restaurants, etc., have dropped appreciably over the past ten years, family outbreaks are still above the 1952 and 1953 figures. It is only fair, however, to point out that these have decreased considerably since 1954.

But this is no time for complacency, for these thousands of "incidents" represent many more thousands of people affected and show the need for more awareness amongst householders.

It is, however, very reassuring to note that, during 1961, there was a reduction of 16% over the 1960 food poisoning incidents. There has been a decrease in all types of food poisoning; in general outbreaks, a reduction of 12½%, family outbreaks 20½%, and sporadic outbreaks 15.9%. The improvements in public catering may well be reflecting some good results of health education. The greatest decrease (37%) was in incidents in which the causal agent was not discovered.

In 1961, two thirds of outbreaks, traced to specific cause, were associated with cold meats which had been re-handled, made-up meats (such as meat pies) and re-heated dishes (such as stews and shepherd's pie). As in previous years, the articles of food most commonly incriminated were processed and made-up meats.

Processed meat was implicated in about half the outbreaks due to salmonellae and staphylococci and almost all the outbreaks due to *Cl. Welchii*.

There was a slight reduction (5%) in incidents due to salmonellae; but they are a continuing problem arising from the transfer of infection by human contacts and by equipment used in the preparation of food.

The places, at which contaminated food was bought or eaten, were recorded in 72% of the general outbreaks; canteens and schools were frequently mentioned; but there was a notable reduction in the number of outbreaks in hospitals and institutions.

The organism most commonly responsible for school outbreaks of food poisoning is *Clostridium Welchii*. Nearly half of the outbreaks (47.2%) in 1960 and (46.85%) in 1961 were due to this cause.

Only four school outbreaks were attributed to salmonella infection in 1961.

Statistics show that people are spending more on food than ever before; and one of the causes of food poisoning in families might be partly due to changes in our food habits. The wide variety of processed foods now available to the housewife - some partly prepared and some deeply frozen - are prepared in excellent and hygienic conditions, and are time and labour saving; but they can easily be contaminated and become a vehicle for food poisoning, if not properly handled and stored.

It is also important to read the instructions carefully on labels of such foods and to comply with the directions for their treatment, cooking and storage.

HEALTH EDUCATION

The Central Council for Health Education has extended its information services to cover the ever widening field of public health.

It continues to supply the department with relevant facts and figures relating to topical subjects and specific problems.

Whilst the food hygiene regulations may help to decrease food poisoning due to organisms other than salmonellae, there will be little difference in the general picture so long as the distribution of contaminated food stuffs is allowed to continue.

In recent years, the search for possible vehicles of infection in the United Kingdom has revealed hitherto unsuspected potential sources of Salmonellae:- American spray dried egg, Chinese and Australian crystalline and liquid egg albumen and liquid whole egg, dessicated coconut from Ceylon, bone meal and fish meal from Central Africa and the Middle East together with imported meats from various

European countries.

These imported food stuffs (egg products, dessicated coconut, meats and animal feeding stuffs) have given rise to a vast reservoir of Salmonella infection.

Research is still proceeding; and it is pointed out that animal feeding stuffs and fertilisers are not however such important sources of human infection as are egg and meat products.

If egg and egg products, meat and meat products, and feeding stuffs and fertilisers could be protected from contamination with salmonella in the first place, or if all products likely to be contaminated with salmonella could be adequately heat-treated, the incidence of food poisoning would fall considerably.

Authorities state there is no evidence to show that food poisoning organisms are present in the flora of newly caught fish or that fish suffer from salmonella infection; but the situation is quite different with poultry and meat. Salmonellae are often present in the intestines of both diseased and healthy animals. The infection may easily be spread in slaughterhouses and food shops or kitchens by dogs, cats, rats, mice or even pigeons, as each of these species may carry the germ. But infection of beef and beef products appears to occur more frequently after slaughter and possibly after the meat has left the slaughterhouse.

"Prevention of salmonella food poisoning depends on knowing more of the potential sources of contamination and is a long term problem; otherwise the remedies for the elimination of food poisoning are simple and can easily be applied".

For the present, the public should note that fresh meat and fish, cooked and eaten when hot, fresh vegetables and fruit and pasteurised milk and canned foods of all kinds are seldom implicated in food poisoning.

In order to encourage good habits of personal hygiene among members of the staff of catering establishments, housewives and others, the Ministry of Health has prepared several illustrated, coloured posters on the subject of food handling, which are a great asset when linked with routine inspection and supervision.

I am indebted to the Information Division of the Ministry for their help during the year.

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References:

1. Dalrymple-Champneys, W. (1960): "Brucella Infection and Undulant Fever in Man". London, OUP.
2. Bothwell, P.W., McDiarmid, A., Bartram, H.G., MacKenzie-Wintle, H.A., and Williamson, A.R. (1962): Vet. Rec., 74, 1091-1100.
3. Based on a letter to The Medical Officer, 9th Nov. 1962, p. 296.

BRUCELLOSIS

The cause of Human Brucellosis and Contagious Abortion in cattle is *Brucella Abortus*. Absence of abortion in a herd does not necessarily signify the absence of infection.

The true incidence of human brucellosis in Britain is unknown because the disease is not notifiable. But Dalrymple-Champneys, 1960 (1) estimated its approximate prevalence as 1,300 cases per annum and Bothwell et al. (1962)(2) supplied evidence indicating there is no "falling off" in known human cases in recent years and that infected raw milk is the most likely vehicle of infection.

Dalrymple-Champneys reported that only 236 of his 1,500 cases have a history of occupational risk; whereas 885 (70.5%) had almost certainly been infected through the consumption of contaminated cows' milk or cream.

It has been demonstrated that there is an association between the consumption of brucella infected milk and a high incidence of infection amongst adults and children - much of which is subclinical.

In an excellent report on Brucellosis Control and Eradication by the Oxford Working Group (Bothwell et. al. 1962), it was stated that at present (i.e. 1960/61) occupationally at risk groups account for 20-25 per cent of cases, when both rural and urban districts are taken into account. This figure may be as high as 50 per cent when rural cases are considered alone. They state that the crux of the problem is the infected animals in the dairy herd.

The main reservoir of brucellosis is the apparently normal cow excreting the organism after a full-term parturition.

Stopping the sale of milk from proven infected cows or enforcing the pasteurisation of milk in such cases is merely palliative and plays no part in eradication of disease in a herd. But it does at least eliminate the 70% human cases, quoted above, who have been infected through the consumption of raw milk.

As Brucellosis has no reservoir in man, elimination of the disease in cattle must result in elimination of human disease.

I am indebted to the Divisional Medical Officer, Cheshire, for most of the foregoing summary on "Brucellosis".

The Oxford Working Group and others have clearly pointed out review of the present legislation in relation to brucellosis is overdue. In fact, the position is so remarkable that it might have happened in Wonderland:-

ALICE IS CURIOUS ABOUT MILK
(With apologies to Lewis Carroll)

Alice was frankly worried. She had heard a lot about Brucellosis lately and wanted to know how she could be sure of not catching it from milk; so, in desperation, she finally turned to the Hatter for advice.

"I like milk; but I only like safe milk" she exclaimed emphatically. "What sort of milk should I get, Sir?" she enquired.

"T.T. milk of course," replied the Hatter, irritably. "Don't ask stupid questions."

But that answer did not entirely satisfy Alice who was feeling in an argumentative mood.

"Why do I have to pay more for raw T.T. milk than for pasteurised milk that I know is safe? Everyone knows T.T. milk is a clean milk; but surely raw T.T. milk may have all sorts of germs in it?"

"You pay of course for the fun of the game. It's a gamble; if you are lucky, you will get an immunity - if not, you may get the disease."

"But I don't want to get Brucellosis, Scarlet Fever or any other milk-borne disease," said Alice peevishly.

"If you get one of those diseases and don't die, you'll get some immunity afterwards, so what's the difference? Let's change the subject," replied the Hatter impatiently.

But Alice wasn't going to be put off. "I simply can't understand why they put the cart before the horse, can you?" she asked, "If only they made Brucellosis of cattle a notifiable disease, the animal doctors would remove the infected cows; then their germs wouldn't get into the milk and give the disease to people with little or no resistance to it."

"Very clever", snapped the Hatter, "but don't you know the disease is also caught from the cows themselves?"

All the more reason for finding and separating the infected cows, thought Alice. But she didn't want to offend the Hatter, so she said, as politely as she could, "Like most people, I don't work on a farm or have anything to do with cows and, in any case, I am only asking about milk."

Alice had shot her bolt, and now she waited for his advice.

The Hatter shook his head and suddenly rocked with laughter, "I suppose you will be saying next that all milk should be pasteurised," he replied scornfully.

"Yes, of course, that's the answer," said Alice triumphantly. "Why ever did I not think of it myself?"

And she thought to herself, "Perhaps the Hatter is not quite so mad after all?"

A C C I D E N T S

(IN THE HOME)

More people are killed by accidents in the home than by accidents on the road, the fact is not really surprising since people spend more time in their houses; but it does mean that we must do everything we can to reduce home accidents.

Over 6,000 persons die annually in England and Wales as a result of accidents in their homes. Most fatalities result from four main causes - falls, poisoning, burns and scalds and suffocation, and of these, about 700 are due to burns and scalds.

More than four-fifths of the fatalities concern the young and the old, and as high a proportion as two-thirds involve infants under one year and elderly people of seventy-five and over who are prone to falls, gas poisoning and burns. The majority of home accidents are preventable.

Thermal Accidents. Statistics about non-fatal accidents are not available, but it is estimated that each year not less than 50,000 persons need hospital treatment for burns and scalds caused by domestic accidents and that about 80% of the deaths, resulting from extensive burns, are due to clothing coming into contact with the heating element or flame of an unguarded or inadequately guarded coal, gas, electric or oil heating appliance. "Open" fires are responsible for more fatal accidents than any other type.

Scalds are a much lower death rate than burns, but the incidence nearly equals that of burns and the degree of disfigurement or disablement may be equally severe. They occur most commonly in children under five years of age, and the most serious accidents result from children falling into buckets or basins if hot water is placed on the floor. They may also be caused by children pulling over themselves vessels, saucepans or pans containing hot fluids or fat or by pulling the flexes of electric kettles.

Electric Blankets. The Fire Protection Association reports that, in the year ended June, 1962, more than 7,000 fires were caused by electric blankets. They injured 61 people, two of whom died.

Most of the victims slept with the blanket switched on.

In spite of the fact that instructions are issued not to fold electric blankets, folding of blankets is given as the main cause of fires. The resultant creasing of the heating element can cause a short circuit or broken element.

The survey says fires have risen out of proportion to the number of blankets in use. They have risen from 11.6 per 10,000 in 1950, when 556,000 were estimated to be in use, to 13.7 per 10,000 in 1961-62, when the estimate in use was 5,557,000.

Burns and Scalds. The Registrar General records that, during the year, 150 children aged 1-14 years lost their lives in their homes from this cause.

Deaths due to Burns and Scalds in England and Wales.
(From the Registrar General's Quarterly Returns)

Period	1962		1961	
	Male	Female	Male	Female
1st Quarter	25	31	10	26
2nd Quarter	7	18	8	11
3rd Quarter	9	7	11	9
4th Quarter	18	35	14	17
TOTAL	59	91	43	63

The Chief Medical Officer to the Ministry of Education reports:-

"Deaths in girls exceeded those in boys, and this is the only important category in which this reversal is found.

Although girls are more likely to be helping with cooking than boys, the most obvious cause is the difference in design and texture of girls' clothes. Day clothes are not so close-fitting, and the hem of a skirt can easily come into contact with an unguarded fire. The same can be said of night clothes as long as nightdresses are preferred to pyjamas for girls.

Where the accident is not fatal, a child may sustain varying degrees of physical injury or of emotional damage and aesthetic defects may persist."

Preventive Measures. The majority of these burning and scalding accidents could be avoided, and, in spite of the publicity that has been given to the subject during recent year, the position has not MUCH improved.

While propaganda of all kinds plays a valuable part in prevention, it is the personal contact of doctors, nurses and social workers with the people in their homes that is likely to bring the most rewarding results.

Efficient Fireguards. The most effective simple way of reducing the number of serious burning accidents is by the use of the properly designed and fixed fireguard of the British Standard Specification. It forms a protection from burning or falling into an open fire, by children tampering with one, or by clothing accidentally brushing against a fire.

Safer Clothing. The most frequent cause of serious burns is clothing catching alight. The provision of fireguards for all types of fires and the choice of safer garments for women and children to wear will reduce these accidents. The flammable nature of nearly all fabrics currently in use makes the guarding of fires doubly important. Pyjamas are much safer than nightdresses, particularly for children. Full skirting party dresses and other loose flimsy garments also require special caution.

It is now possible to buy children's clothing made of flame resistant material; you can also buy materials to make up yourself. It may be slightly more expensive, but surely it is worth spending about two shillings a yard more to prevent serious burns to young children.

Prevention of Scalding Accidents. Although, in some cases, scalding accidents may be precipitated by the shape, design and use of the kitchen or by the form of domestic equipment, it is nevertheless clear that the majority of incidents are due to carelessness.

While the final responsibility for the prevention of burns and scalds in the home must rest with the householders, every authority, organisation and individual has something to contribute to the provision of safety in the home and it is only by the combined efforts of everyone that the incidence of burns and scalds can be reduced.

ACCIDENTS
(ON THE ROAD)

For the first time since 1952, road casualties in Britain fell by 2% with 199 fewer deaths. The decrease was mainly due to a reduction in motorcycle and pedal cycle casualties.

67% of deaths on the road were the result of head injuries.

(a) Motorcycles

Motor cycle casualties fell by 12% and pedal cycle casualties by 9% compared with 1961, but it may well be that many more people are taking to cars in preference to the seemingly more vulnerable motorcycle.

90% of motor cyclists' deaths were from head injuries.

Injuries to Motorcyclists

	Killed	Serious	Slight
1954	1,148	15,847	35,536
1961	1,544	26,085	67,673
1962	1,323	24,256	61,034

It will be noted from the above table that the rate of increase in the number of deaths in 1961 compared with 1954 was considerably less than that of injuries. The reason for this lower rate of deaths may be because many more people were wearing safety helmets in 1961 and were therefore injured and not killed.

There was a pleasing reduction in all three categories of casualties during 1962; but the level is still very much higher than in 1954.

I am indebted to the Royal Society for the Prevention of Accidents for the figures of casualties to riders and passengers of motorcycles and mopeds in Great Britain.

The Road Research Laboratory has revealed that the wearing of a safety helmet reduces by 30% to 40% the risk of head injury.

A man on a motorcycle is about 18 times more likely to be injured than a man inside a car; and the damage is far greater.

(b) Motor Cars

The number of deaths and seriously injured in cars increased by 4%.

Casualties among users of goods vehicles rose by 9%.

Car Seat-Belts

A recent report* on an analysis of the injuries sustained by car occupants, by two members of the Road Research Laboratory, gives details of 600 car accidents in which 837 drivers or front seat passengers were wearing seat-belts.

The following is an extract from the article:-

"The seat-belts were of types approved by the British Standards Institution.

For purposes of comparison, the seat-belts of different makes can be divided into four types:-

The full harness, the lap and diagonal with pillar fitting, the lap and diagonal with floor fitting and the diagonal only.

No fatalities are included and there are indications that slight accidents are not fully represented; but there is no reason to suppose that these defects affect the comparisons made.

All types of seat-belt were effective in reducing injuries to the user: when the seat-belts were worn, the percentage not injured was 66%; whereas, in the sample in which either the belt was not worn or there was no belt available, the percentage of persons not injured was only 32%.

The percentage of persons not injured while wearing a seat-belt was about the same for each of the different types of seat-belt, but there were slight differences in the pattern of the injuries:-

Where the diagonal belt was worn, injuries to the head and neck were slightly less than for the other types of belt, but injuries to the chest were slightly greater.

A single diagonal belt, which has one anchorage on the door pillar and one on the floor, usually provides more restraint for the upper part of the body than belts that have all-floor anchorage points. Injuries involving the head are therefore less likely with the single diagonal belt, but slight chest injuries are more likely.

Although the numbers are small, the lap and diagonal belt with a pillar fitting gives rise to a smaller proportion of serious injuries than the lap and diagonal with floor fitting.

The percentage of injuries to the legs and feet was practically the same for all types of seat-belt and was only slightly greater when either no belt was worn or there was no belt available, since the legs and feet are relatively unrestrained in each case.

The overall reduction in injuries through wearing the belt was 51%. Serious injuries were reduced by about 80%.

This survey shows that, in August, 1962, about 7% of cars studied were fitted with seat-belts. Thus, in spite of the considerable benefits to be derived from their use, seat-belts are still not widely fitted and worn."

*"The Practitioner" September 1963 Vol. 191 by R.D. Lister and Barbara M. Milson.

ACCIDENTS (IN THE WATER)

During 1962, there were 690 deaths from drowning in Great Britain:- 79% were males, nearly one third were children under fifteen; and one in five was aged sixty-five or over.

In an excellent report on "Drowning", Dr. C.A. Boucher of the Ministry of Health has emphasised the following important facts:-

"It is maintained that inland waters - particularly rivers, canals and quarries - constitute a greater danger, especially to children, than coastal waters. The Coastguard Section of the Ministry of Transport reported small-boat and bathing incidents in 1961 in which 736 persons were involved and 90 were drowned."

The case histories of the Royal Humane Society suggest that non-swimmers are usually the victims and make it clear that panic is the greatest danger to survival.

In a survey of entrants into the Royal Navy, recruits to the Army and students in training colleges, two thirds were unable to swim. At the same time, two out of three children who left school were also found to be unable to swim.

PREVENTION: Prevention of drowning accidents depends on education stressing the dangers of water, particularly of deep or swiftly flowing water. Water safety should be as widely taught to children as road safety. Parents should encourage their children to learn to swim.

The Royal Society for the Prevention of Accidents has published a Water Safety Code and, for those who sail, a booklet entitled "Safety Afloat".

According to "WHICH" -

"A good life-jacket will not only keep you up, with your face and nose clear of the water; it will turn you over, within a few seconds, into the safest position - that is, on to your back and leaning back at an angle of roughly 45° , your feet down in the water, your face well out of it".

This position - at 45° to the surface of the water - tends to prevent the head from falling forwards and is a good compromise between the vertical and horizontal. In a vertical position, waves will cause periodical immersion of the head and possibly sea sickness; while, in an horizontal position, the tongue may block the throat.

According to British Standards Institution:- "any life jacket made to B.S. 3595 and bearing the kite-mark will be of a very high standard indeed. We hope that, by next spring (1964), several kite-marked jackets will be on the market, and that yachtsmen will equip themselves only with these approved models".

A First Aid Supplement on Emergency Resuscitation has recently been published by the St. John Ambulance Association, the British Red Cross Society and the St. Andrews Ambulance Association.

ACCIDENTS (CHILDHOOD DEATHS)

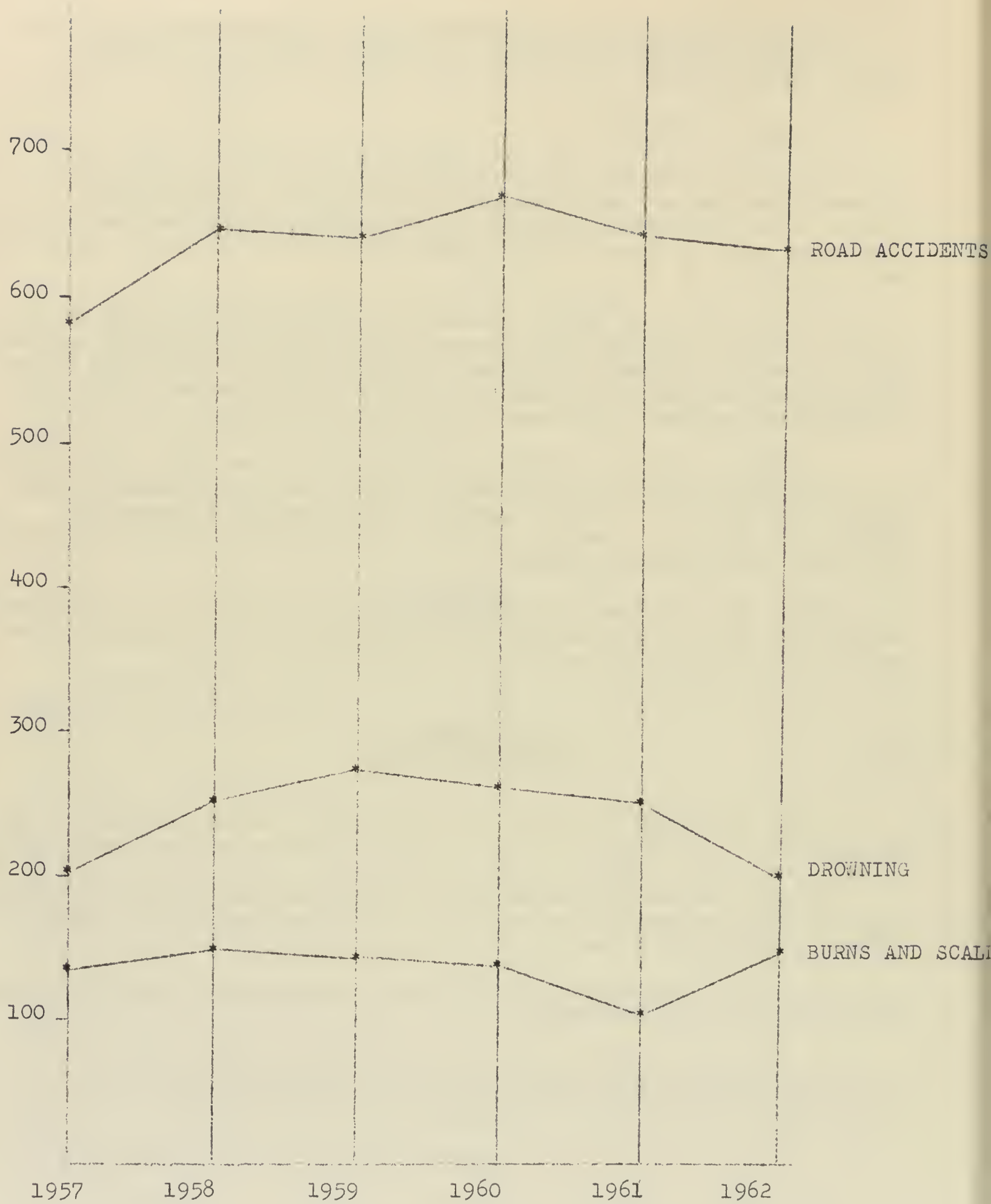
Accidental deaths in childhood (0-15 years) account for 39% of all deaths in this age group and also for more deaths than any single disease.

They must be attributed mainly to inadequate supervision; but carelessness, thoughtlessness, apathy and lack of knowledge of the adults in charge, all play their part.

The greatest effort in prevention is needed against road accidents, burns and scalds and drowning.

The following record of the number of child deaths over the last six years emphasises the need for far more vigilance on the part of those responsible for their training, care and supervision.

DEATHS AMONG CHILDREN
(0 - 15 years)



DROWNING:

During the year, 200 children lost their lives as a result of drowning.

Drowning can occur at home, but this is usually in infants in the first year of life, in the bath; it is quite a different problem from drowning outside the home.

Deaths due to Drowning in England and Wales 1962 and 1961.

	1962		1961	
	Male	Female	Male	Female
1st Quarter	35	3	38	8
2nd Quarter	57	8	67	11
3rd Quarter	65	10	86	23
4th Quarter	20	2	18	3
TOTAL	177	23	209	45

The Chief Medical Officer of the Ministry of Education reports:-

"A child may drown as a result of entering deep water while bathing, when he is an inadequate swimmer; or from falling into deep water from dry land, when he had no intention of bathing; or through an accident whilst he is in or on the water, the methods of prevention are widely diverse. In the first group, proficiency of swimming and in learning to appreciate water hazards should reduce casualties. In places where currents are strong or beaches shelve rapidly, the inadequate swimmer needs protection by warning notices.

On bathing-beaches, where conditions are occasionally dangerous and beach-guards are provided to warn bathers, school children will commonly respond as if they were under the care of a teacher of physical education. This safety measure is likely to be wasted, however, if adult bathers refuse to accept the advice of the beach-guard.

In the case of drowning, an accident is either fatal, or followed by complete physical recovery; and, in many instances, skilled first aid measures suffice.

ACCIDENTS
(OLD PEOPLE)

The accident rate is high in old people. With increase in age, physical and mental deterioration may reduce the capacity to co-ordinate thought and action. Some old people become fatigued, forgetful or absent minded, and these psychological features may be accompanied by physiological changes, failing vision, impaired hearing and sense of smell, and muscular weakness; and the infirm and the handicapped are liable to accidents through inexpert handling of heating and lighting appliances and inability to avoid obvious hazards. Falls account for nearly two-thirds of fatal home accidents and nine-tenths of these fatalities affect people of sixty-five and over.

The majority of the victims are women.

OLD PEOPLE'S WELFARE

In this District there are two Old People's Homes, under the control of the County Council, which provide accommodation for old people from all parts of the county - Kitnocks House, Curdridge (Telephone, Botley 2553) and Corhampton House, Corhampton (Telephone, Droxford 20).

I am indebted to Mr. F.J. Bryan Long, County Welfare Officer, for the following information on the County Council's Scheme for permanent and short stay accommodation in Old People's Homes, and for placing elderly people in private households under the County Council's Placement Scheme.

Admissions to Old People's Homes during the year ended 31st December, 1962.

Altogether 247 persons were admitted during the year, this represented a turnover of 28.8% of the average total of 857 beds provided in the County Old People's Homes. Included in these admissions were 85 or 34.4% of the total direct from hospital.

Provision of Short Stay Accommodation in Old People's Homes.

The Welfare Committee of the County Council operate a scheme whereby any places temporarily vacant in the County Homes for old people are made available to elderly persons to enable the relatives or friends with whom they live to take a holiday.

Such temporary vacancies arise when residents are in hospital or away on holiday and when a new resident needs time to clear up his affairs. Some use is also made of sick bays during the summer months when there is less demand for nursing care.

This scheme enables people, who normally look after aged relatives, to obtain temporary relief from responsibilities they have undertaken whilst they go on holiday or occasionally when they themselves are ill.

During the year 1962, altogether 128 old people were admitted to Old People's Homes under the scheme, in addition to the 247 permanent admissions. In this area there were 15 admissions (including 2 temporary admissions) to Old People's Homes. In addition 141 visits were paid to aged and infirm and handicapped persons.

Accommodation under this scheme cannot be offered to old people needing regular medical and nursing care; generally they should be able to wash and dress themselves, get to the dining room for meals and attend to their own toilet.

Applications for short stay admission may be made either to the local Area Welfare Officer or direct to the County Welfare Officer at The Castle, Winchester.

County Placement Scheme.

The Welfare Department first began a "home finding" scheme in 1952. It is a scheme for placing elderly people, who are active enough not to need constant care and attention, in suitable private accommodation; and it is proving very successful in maintaining the independence of old people and in finding suitable accommodation for them.

There are many old people today living alone who may have accommodation which they would be glad to share with an elderly person, and whose companionship would enable them to live a fuller life and offset loneliness.

No average charge figure is available. Terms are negotiated separately in each case in the light of the standard of accommodation and services offered, the financial resources of the applicant and any other relevant factors.

Foster homes are found through press advertisements and contacts through voluntary and statutory bodies.

Foster homes are found mainly on a short stay basis, but considerable numbers of people are permanently boarded. Some old people often share a home with another. Alternative action to boarding out is considered when applications are made. Visiting is done by County Welfare Officers. A geriatric social worker has been appointed to co-ordinate and develop the Placement Scheme and to specialise to a greater degree in bringing together people with similar interests. It is also intended to make follow-up friendly visits to give advice and practical assistance to assure them that somebody is available to help them solve their problems.

NATIONAL ASSISTANCE ACT

No official action was taken under the National Assistance (Amendment) Act, 1951, during the year in connection with the removal to hospital of persons "who are suffering from grave, chronic disease or, being aged, infirm or physically incapacitated, are living in insanitary conditions, and are unable to devote to themselves, and are not receiving from other persons, proper care and attention."

One potential case was investigated and kept under supervision.

The assistance given by the General Practitioners, the Welfare Officer, Public Health Inspectors and Health Visitors, is greatly appreciated in these difficult and distressing cases.

CHIROPODY SERVICE

Very good Chiropody services have been established for old people by the British Red Cross Society, the Hampshire Council for Social Service and the numerous local Old People's Welfare Committees.

The Minister of Health has suggested that, at this stage, priority should be given to the elderly, the physically handicapped and expectant mothers and that Local Health Authorities might wish to develop their Schemes by using existing voluntary services.

The Hampshire County Council will make grants to both the British Red Cross Society and the Hampshire Council for Social Service; and the latter will make small grants to the various Local Old People's Welfare Committees.

Further development of the Chiropody Service in relation to the physically handicapped and expectant mothers will be dealt with through the British Red Cross Society.

HOME HELP SERVICE

The Home Help Divisional Office is situated at the rear of The Town Hall, Petersfield (Telephone, Petersfield 771 Extension 18) and is open Mondays to Fridays, 9a.m. - 12 Noon, when Mrs. Holmes or her clerical assistant, Mrs. Wilson, will be available. Application for Home Help should be made to this office. Urgent messages can be left at The Town Hall up to 5.30p.m. Monday to Friday; evenings and weekends Telephone Horndean 3516.

INTERNATIONAL TRAVEL

Travellers from abroad, who may have been contacts of smallpox or other dangerous diseases while out of this country, are required to show their doctors notices issued to them on arrival at airports in the event of their becoming ill during the succeeding twenty-one days.

Passengers undertaking international travel must be in possession of certain vaccination certificates, depending upon the place of departure, the countries of transit and the destination. International certificates are issued in connection with smallpox, yellow fever and cholera.

All persons travelling from any place in Asia, Africa or the Americas, (excluding Canada and the U.S.A.) or from any smallpox-infected local area wherever it may be, are now required to produce a valid International Certificate of Vaccination against smallpox on arrival in the country.

The International Sanitary Regulations, 1956, specify the following periods for the validity of International Certificates of Vaccination:-

<u>Type of Vaccination</u>	<u>Validity (after date of Vaccination or inoculations)</u>	
	<u>Begins</u>	<u>Ends</u>
Smallpox - primary vaccination	8 days	3 years
Smallpox - re-vaccination	At once	3 years
Cholera - primary vaccination	6 days	6 months
Cholera - re-vaccination	At once	6 months
Yellow Fever - primary vaccination	10 days	6 years
Yellow Fever - re-vaccination within six years	At once	6 years

Smallpox vaccination within the previous three years is required before entry into many countries.

Yellow fever inoculation during the preceding six years is required before entering or passing through regions of Central and South America or Africa, designated as "Yellow Fever Receptive Areas".

For travel into or through countries where cholera is endemic (India, Pakistan, Burma, etc.) immunisation against cholera within the preceding six months may be required. But the health authorities of some countries vary these periods and details of immunisation requirements can be obtained from the airline or steamship company concerned, or from the Consulates of the countries to be visited.

Persons, who are required to be vaccinated or inoculated against more than one disease, are advised to tell the doctor of all the vaccinations or inoculations needed as they may have to be done in a particular order with certain minimum intervals.

The vaccinations against smallpox and cholera must be recorded on the International Certificate form prescribed by the World Health Organisation, dated and signed by the doctor doing the inoculation, authenticated and stamped at the office by the Health Department of the District.

The International Certificate forms for smallpox and cholera vaccinations must be obtained (by the traveller himself) from the travel agency or Ministry of Health; those for yellow fever are obtained at certain recognised centres where the vaccination is performed.

In this area, yellow fever vaccinations are carried out at The Health Centre, Kings Park Road, Southampton, once a week (on Wednesdays) and the traveller is advised to make an appointment by telephone - Southampton 23788.

SMALLPOX VACCINATION

The speed of air travel makes the task of preventing the imported case of smallpox particularly difficult; so the earliest possible detection of the disease is of the utmost importance in preventing the spread.

Outbreaks of smallpox in this country generally arise from the importation of the disease from abroad; smallpox may be introduced into this country in an insidious way through the entry of persons in apparent good health, but in whom smallpox is incubating.

In such circumstances, the disease - modified by vaccination - has often gone unrecognised until it has appeared in classical form in others exposed to infection.

For the period - December 1961 to April 1962 - there were no less than five separate importations of smallpox to this country, from Karachi where a considerable epidemic existed from November 1961 to February, 1962. At the same time, large numbers of Pakistani immigrants were travelling here by charter flight and at minimal fares.

In these outbreaks, there was a total of 67 cases with 26 deaths giving a fatality rate of 39% - some indication of the lethal nature of smallpox, a disease for which there is no specific treatment.

The basis for smallpox control is to isolate the case, seek out and vaccination all contacts, and keep them under effective surveillance.

Indiscriminate mass vaccination has seldom any value in the control of a smallpox outbreak. While it may be difficult for the public at large to resist the temptation to ask for vaccination whenever an epidemic threatens, it must be appreciated that any demand for wholesale vaccination will only result in diverting the medical manpower from its main line of attack.- namely, the tracing, vaccination and surveillance of contacts. In an emergency, available lymph should be used for the vaccination of contacts (who should receive first priority), of babies and of travellers abroad.

There is no evidence to justify the suggestion that outbreak control alone would necessarily prove effective in an unvaccinated population; so routine vaccination should continue in early childhood.

For some years, the low acceptance rate and the resulting lack of protection to the individual and the community has caused much concern; the aim should be to see that every healthy infant is vaccinated - not only because routine vaccination in early life is thought to be justified as the first step in establishing a satisfactory immunity in later years, but also on account of the immediate protection thereby conferred, and the occurrence of outbreaks of imported smallpox from time to time only confirms that the extent of immunity against this disease is not sufficient to prevent an epidemic.

Vaccination protects the individual from smallpox in most instances for several years and can be expected to modify the severity of the disease and reduce the risk of death for a much longer period.

The Ministry of Health recommends routine primary vaccination in the first two years (preferably in the second year) for all infants except the few in whom the well-defined contraindications to routine vaccination exist.

The importance of primary vaccination as a routine is that the anti-body response to revaccination, when persons are placed at risk, is likely to be more rapid and to reach a higher level than can be attained by primary vaccination. In other words, the boosting stimulus of revaccination will ensure a rapid and high level of immunity to smallpox infection.

If the first vaccination is put off until adolescence or later, there may be a slight risk; and, since many persons will need to be vaccinated at some time, it is highly desirable that this should be done early in life - if only as an insurance against possible untoward effects of vaccination later on.

Smallpox is no longer endemic in Europe and the chance of the individual stay-at-home Englishman ever encountering it may be remote, but not everyone remains at home and vaccination is often a pre-requisite for travel or for entry into many countries, as well as an essential for personal protection in those areas in which smallpox is endemic. It is necessary in certain types of employment

within this country and obligatory for service with the Armed Forces.

So, the probability is that for one reason or another a substantial number of residents in this country will find it desirable to be vaccinated on some occasion during their lives.

The susceptibility of the community as a whole to epidemic smallpox of either the mild or the severe variety cannot be greatly diminished by routine infant vaccination alone. To guard against the social disruption and economic loss which invariably results from the rapid spread of any form of smallpox, it is necessary for the re-vaccination of school children as well as vaccination of infants to be done as a routine.

The re-vaccination of children between the ages of eight and twelve years not only maintains or revives their individual protection, but is likely to facilitate substantially the control of local outbreaks of smallpox. It also ensures that any further vaccination in later life will be less likely to have any serious reactions or complications.

Re-vaccination carried out at school age, is practically trouble free; and this procedure, done as a routine at least once on all children primarily vaccinated in infancy, would substantially diminish the chance of rapid spread of smallpox. So it is hardly surprising that the Ministry is now strongly urging that re-vaccination of school children should be encouraged.

It is unfortunately something of a paradox that the application of preventative measures, so easily and fully available, should in a great many instances have to await the occurrence of the very condition they are designed to prevent before advantage is taken of them.

During the year, 2,808 vaccinations against smallpox were carried out:-

Vaccination	Pre-School Children	School Children	Over 15 years of age
Primary	358	308	277
Re-vaccination	317	611	937
TOTAL	675	919	1214

DIPHTHERIA IMMUNISATION

The following information has been based on reports from the Ministry of Health and Registrar General and on pamphlets issued by the Central Council for Health Education.

England and Wales	1958	1959	1960	1961	1962
Cases	80	102	53	52	16
Deaths	8	-	5	10	2

It will be noted from the above table that the incidence of diphtheria has fallen considerably since 1959; in fact, this is the lowest figure recorded since the introduction of compulsory notification of this disease. But two of the sixteen cases died - a fatality ratio of 12.5 - which underlines the substantial risk of death to those who become ill with diphtheria.

It will be seen that there was also a rise in mortality in 1961. All these facts remind us that this disease is still a "killer" and could again become a serious menace.

During 1962, the only outbreak was in Glamorgan, where cases occurred. The difficulty created by such an outbreak are illustrated by the fact that 147 "carriers" were discovered during the investigation in Glamorgan. These were admitted to hospital and treated to eliminate their carrier state.

None of the confirmed cases of diphtheria in 1962 had been effectively immunised against that infection; indeed, only three had had any anti-diphtheria inoculation at all.

For some years, attention has been drawn to the serious position that would arise if a high level of immunisation of children is not reached and, thereafter, maintained.

Before the nation wide Immunisation Campaign was started in 1943, the average incidence was 50,000 a year. The scheme quickly got under way and resulted in a steady drop in the number of cases until 1958. Although complete eradication of the disease from an area where cases occur endemically is not an easy matter, there is evidence that there are good prospects for maintaining freedom - once it has been gained - if only immunisation is generally accepted.

Experience over the last few years has shown that in school communities where immunisation rates are low, diphtheria infection, when once introduced, can gain momentum and lead to an outbreak. The need for early immunisation and for booster doses is therefore stressed.

A more complete protection in the under 5 age group would soon cause reduced incidence in the early school (5-9) age group and the disease might well be almost eliminated. Only if an adequate level of immunisation is maintained, can diphtheria be driven altogether from this country.

The great majority of parents nowadays have never known or heard of a case of diphtheria among local children and are more afraid of illnesses they know; but, if they leave their children unprotected, they may gain knowledge of this disease from personal experience.

Complacency, resulting from what has already been achieved, or loss of interest in immunisation, may mean that diphtheria will go on occurring endemically and epidemically in this country indefinitely, with the ever-present risk of a return of high mortality; but a vigorously continued immunisation programme, combined with existing methods of epidemic control, may free us entirely from the disease - except for the occasionally imported case.

Authorities recommend that all children should be immunised before their first birthday and should receive a booster or reinforcing dose just before entering school, and again when they are about ten years old. If immunisation is carried out before the age of six months, an extra booster is advised at fifteen to eighteen months.

Immunity against diphtheria takes several weeks to develop; but a booster given to those who have been inoculated earlier in life, will produce rapid protection.

It is, therefore, of the utmost importance for parents to realise that active immunisation in the first year of life and reinforcing doses of prophylactic in later years are just as necessary in the absence of diphtheria epidemics as in their presence.

The Ministry of Health reports that the percentage of children in England and Wales, who may be regarded as "remaining protected against diphtheria" during the past two years, are as follows:-

Age Groups	1961	1962
Under 5 years	64%	65%
Under 15 years	51%	54%

In this District 69.2% of the children born during the year 1961, were immunised before they attained the age of one year.

Children up to five years of age are the most susceptible; but all school children should be immunised.

During the year 466 immunisations against diphtheria were carried out:-

Immunisation	Pre-School Children	School Children
Diphtheria - Primary	-	10
Diphtheria - Re-inforcing or "Booster"	-	4
Diphtheria/Whooping Cough Combined - Primary	2	1
Diphtheria/Whooping Cough Combined - "Booster"	-	2
Diphtheria/Tetanus "Booster"	4	26
Triple - Primary	290	7
Triple - "Booster"	32	88
TOTAL	328	138

In this District, immunisation of children is generally carried out by their own doctor.

WHOOPING COUGH IMMUNISATION

This Council was the first Council in Hampshire, and indeed, one of the first in the country, to adopt a Whooping-Cough Immunisation Scheme. The Council's Scheme for Whooping-Cough Immunisation by general practitioners was commenced in 1942.

At the beginning of 1955, the Hampshire County Council's Scheme for Whooping-Cough Immunisation began operating throughout the whole of Hampshire.

The scheme includes combined immunisations against Whooping-Cough and Diphtheria, and triple immunisation against Whooping-Cough, Diphtheria and Tetanus; it also provides for immunisation against Whooping-Cough alone under the age of five years.

The final report of the Whooping Cough Immunisation Committee of the Medical Research Council, designed to test the effectiveness of newer vaccines, confirmed that combined Diphtheria/Pertussis vaccine was as effective as the pertussis vaccine alone.

The Medical Research Council concluded that pertussis vaccines, which come up to the required standard, will provide "substantial protection" against the disease.

In general, a reduction of about 10% of the uninoculated (or a 90% protection) may be expected.

But it will be appreciated that the problems of diagnosing an attack of Whooping Cough, modified by immunisation, are already common and troublesome in general practice.

Combined Whooping Cough and Diphtheria immunisation with or without Tetanus is often preferred for the primary immunisation of young children, so as to reduce the total number of inoculations needed for immunisations against three infections.

Whooping Cough immunisation is generally advised early - at about the third or fourth month.

During the year, 322 immunisations against Whooping Cough were carried out, as shown by the table in the section on Diphtheria Immunisation.

POLIOMYELITIS VACCINATION

In May, 1956, the County Council's scheme for Poliomyelitis vaccination of children, born in the years 1947-54, began in selected areas of Hampshire. The age limit was extended in 1957 and 1958, and by 1959, the age group for registration was raised to twenty-six and the vaccinations were carried out as supplies of vaccine became available.

In February, 1960, it was further extended to include persons up to the age of forty years of age.

In April 1961, arrangements were made for fourth injections of Salk vaccine to be offered to children between five and twelve years of age.

In February 1962, oral vaccine was made available for the routine immunisation of special groups as an alternative to the inactivated Salk Vaccine.

During the year 1,736 vaccinations against poliomyelitis were carried out.

Vaccination	Pre-School Children	5-15 Years	15-40 Years
Primary	99	22	54
Booster	381	109	463
4th Injection	176	418	14
TOTAL	656	549	531

The success of this scheme is due not only to the general practitioners who have given practically all the inoculations, but also to the parents who have so wisely seized the golden opportunity.

PERSONAL PRECAUTIONS AGAINST POLIOMYELITIS

The World Health Organisation has issued six points for the personal protection of the public against Poliomyelitis.

The six rules for the individual to observe are as follows:-

1. Wash hands frequently, especially before eating.
2. Protect food from flies; thoroughly wash uncooked food, such as fruit and vegetables.
3. Avoid intimate association, such as shaking hands with families in which poliomyelitis has occurred within three weeks.
4. Treat feverish illnesses with caution; bed rest, or at least avoiding over-exertion for a week is advisable.
5. Avoid over-exertion.
6. Avoid unnecessary travel to and from communities where the disease is prevalent.

PREVALENCE OF, AND CONTROL OVER, INFECTIOUS
AND OTHER DISEASES

Particulars of the cases of Infectious Diseases, which were notified during the year and comparative notification rates for the whole of England and Wales, are shown in the following table:-

Diseases	Total Cases Notified	Rate per 1,000 of the Population	
		Droxford R.D.C.	England & Wales
Measles	17	0.73	3.96
Pneumonia	2	0.08	0.27
Meningococcal Meningitis	1	0.02	0.01

An analysis of the total notified cases according to age groups is given below:-

Age Group				Measles	Pneumonia	Meningococcal Meningitis
Under 1 year	...	...		-	-	-
1 - 2 years	...	...		2	-	-
2 - 3 "	...	...		2	-	-
3 - 4 "	...	...		2	-	-
4 - 5 "	...	...		2	-	-
5 - 10 "	...	...		6	-	1
10 - 15 "	...	...		1	1	-
15 - 20 "	...	...		2	-	-
20 - 35 "	...	...		-	-	-
35 - 45 "	...	...		-	1	-
45 - 65 "	...	...		-	-	-
Over 65 "	...	...		-	-	-
TOTALS ...				17	2	1

The following table shows the number of infectious diseases notified during the year, and the parishes in which they occurred:

Parish	Measles	Pneumonia	Meningococcal Meningitis
Bishop's Waltham	-	-	-
Boarhunt	-	-	-
Corhampton and Meonstoke	1	-	-
Curdridge	-	-	-
Denmead	-	-	-
Droxford	11	-	-
Durley	-	-	-
Exton	-	-	-
Hambledon	1	1	-
Shedfield	2	-	1
Soberton	-	-	-
Southwick and Widley	1	-	-
Swanmore	1	-	-
Upham	-	-	-
Warnford	-	1	-
West Meon	-	-	-
Wickham	-	-	-
TOTALS	17	2	1

TUBERCULOSIS

At the end of the year, the total number of cases on the register was 261.

The following table gives the number of cases of Tuberculosis registered in the district at the beginning and end of 1962:-

	Respiratory			Non-Respiratory		
	M.	F.	Total	M.	F.	Total
Number on Register at beginning of the year (1962)	114	76	190	26	33	59
New additions to the Register during the year	13	5	18	-	1	1
Removals from the Register during the year	6	1	7	-	-	-
Number on Register at end of the year	121	80	201	26	34	60

Analysis of new cases and deaths according to age groups:

Age Period	New Cases				Deaths			
	Respiratory		Non-Respiratory		Respiratory		Non-Respiratory	
	M.	F.	M.	F.	M.	F.	M.	F.
0 - 1	-	-	-	-	-	-	-	-
1 - 5	-	-	-	-	-	-	-	-
5 - 15	-	-	-	-	-	-	-	-
15 - 25	-	1	-	1	-	-	-	-
25 - 35	1	2	-	-	-	-	-	-
35 - 45	5	1	-	-	-	-	-	-
45 - 55	1	1	-	-	-	-	-	-
55 - 65	3	-	-	-	-	-	-	-
65 and over ...	3	-	-	-	3	-	-	-
TOTALS	13	5	-	1	3	-	-	-

MASS RADIOGRAPHY SURVEY

During the year, the Southampton Mobile Mass X-ray Unit visited four villages in this district. 894 persons attended and the results were very satisfactory.

SCABIES

Facilities for the treatment of Scabies are available at Portsmouth Disinfestation Clinic.

Appointments for cases requiring treatment are made through this Department.

Scabies should be regarded as a family infection; and all members of the same family should present themselves for treatment simultaneously - whether or not they complain of "The Itch" and show evidence of scabies at the time. Otherwise an early case may escape detection and the parasite may thrive in one member and re-infect the others.

PEDICULOSIS

Where necessary, cases of Pediculosis (head lice) may be referred for treatment, by special appointment, at any of the following centres:

Fareham
Eastleigh
Petersfield

whichever is the most convenient.

Pediculosis should also be regarded as a family infection; and, when a child is found to be verminous, all the members of the family should offer themselves for examination. This wise practice would ensure that any undetected case in the family would receive immediate treatment and that there would be no further spread of infection to others.

MARIE CURIE MEMORIAL FOUNDATION

The above Foundation operates a scheme whereby help can be given to meet the urgent needs of necessitous cancer patients being nursed at home. The County Medical Officer has been appointed as agent for the County Scheme which will provide these patients with help 'in kind' (e.g. linen, bedding, laundry necessities, special equipment for the comfort of the patient, etc.)

THE REPORT OF THE SURVEYOR
AND CHIEF PUBLIC HEALTH INSPECTOR

SANITARY CONDITIONS OF THE AREA

Water Supply

Piped supplies throughout the District are provided by the Portsmouth and Gosport Water Company, the Southampton Corporation and two private estates. Regular reports of bacteriological examinations are received from the Portsmouth and Gosport Water Co. indicating that the samples are of excellent quality.

Details of supply are as follows:-

Portsmouth and Gosport Water Company

<u>Parish</u>	<u>Dwellings</u>	<u>Population</u>
Bishop's Waltham	862	3,017
Boarhunt	98	343
Corhampton and Meonstoke	142	497
Denmead	768	2,688
Droxford	140	490
Durley	79	276
Exton	39	136
Hambleton	257	899
Shedfield	537	1,879
Soberton	335	1,172
Southwick and Widley	119	417
Swanmore	469	1,641
Upham	148	518
West Meon	153	535
Wickham	477	1,669

Southampton Corporation Water Undertaking

<u>Parish</u>	<u>Dwellings</u>	<u>Population</u>
Curdridge	308	1,232
Durley (part)	149	596
Wickham (Part)	21	84

Drainage and Sewerage

Bishop's Waltham

The new sewage works were completed and brought into operation in May, 1962. By the end of the year 717 properties were connected to the sewers.

Wickham

Work on this scheme commenced in October and satisfactory progress had been made by the end of the year.

Public Cleansing

The cesspool emptying scheme, which allows for four free emptyings per year, continues in operation, as does the collection of night soil and household refuse.

The upward trend in cesspool emptyings continues.

The following summary gives particulars of work carried out during the year under review:-

<u>Dustbin</u>	<u>Cesspool Emptyings</u>		<u>Cesspool Loads</u>		<u>E.C.</u>
<u>Emptyings</u>	<u>Council</u>	<u>Contract</u>	<u>Council</u>	<u>Contract</u>	<u>Emptyings</u>
319,599	6,685	750	14,371	1,274	114,857

Household refuse is collected by direct labour, fortnightly throughout the district with the exception of Bishop's Waltham, Shedfield and Wickham, where collections are weekly.

Salvage

The total receipts were £1,578. 3s. 6d., a decrease of £151. 3s. 5d., on the previous year. All grades of waste paper prices were reduced in April due to overstocking at the mills, but this was partially off-set by a small increase in tonnage collected. There was also a reduction in amounts collected of most items.

The following amounts of salvageable materials were collected:-

	Tons	Cwts.	Qtrs.	Lbs.
Waste Paper	219	12	2	1
Steel and Iron	6	15	3	-
Mixed Metals	-	11	2	13
Rags and Woollens	7	-	3	27
Bottles.....	263 gross.			
Tyres.....	45 (in number)			

Comparative figures of waste paper collection are set out below:

	1960	1961	1962
Weight -	234 tons, 12 cwts.	217 tons, 16 cwts.	219 tons, 12 cwts.
	1 qtr. 25 lbs.	- qtrs. 4 lbs.	2 qtrs. 1 lb.
Receipts-	£1,494. 17s. 0d.	£1,393. 0s. 10d.	£1,322. 0s. 7d.

HOUSING STATISTICS (Public Health)

Inspection of Dwelling-houses during the year:

(1)	(a)	Total number of dwelling-houses inspected for housing defects (under Public Health or Housing Acts)	32
	(b)	Number of inspections made for the purpose...	102
(2)	(a)	Number of dwelling-houses (included under sub-head (1) above) which were inspected and recorded under the Housing Consolidated Regulations, 1925 and 1932	12
	(b)	Number of inspections made for the purpose...	56
(3)		Number of dwelling-houses found to be in a state so dangerous or injurious to health as to be unfit for human habitation	12
(4)		Number of dwelling-houses (exclusive of those referred to under the preceding sub-head) found not to be, in all respects, reasonably fit for human habitation	Nil

Remedy of Defects during the year without service of formal Notices:

Number of defective dwelling-houses rendered fit in consequence of informal action by the Local Authority or their officers	3
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Action under Statutory Powers during the year:

(a)	Proceedings under Section 9, 10 and 16 of the Housing Act, 1957:-	
(1)	Number of dwelling-houses in respect of which Notices were served requiring repairs ...	Nil

(2) Number of dwelling-houses which were rendered fit after service of formal notice:

(a) By Owners Nil

(b) By Local Authority in default of owners Nil

(b) Proceedings under Public Health Acts:-

(1) Number of dwellings in respect of which Notices were served requiring default to be remedied 4

(2) Number of dwelling-houses in which defaults were remedied after service of formal notice

(a) By Owners 2

(b) By Local Authority in default of owners Nil

(c) Proceedings under Section 16 (4), 17 (1) and 24 Housing Act, 1957:-

(1) Number of dwelling-houses in respect of which Demolition Orders were made 3

(2) Number of dwelling-houses demolished in pursuance of Demolition Orders Nil

(3) Undertakings given 2

Overcrowding

Statutory overcrowding does exist in a minor degree within the area, but, under existing circumstances, no direct action is taken; cases are referred to the appropriate Committee for consideration when allocating new houses. One case was investigated and abated by informal action.

Housing Act, 1949.

Housing Repairs and Rents Act, 1954.

Rent Act, 1957.

Rents Act Inspections Nil

Improvement Grant Inspections 275

New Houses and Buildings

Comparative figures are given for the last nine years:

Number of plans approved by the Council:

Type of Plan	1954	1955	1956	1957	1958	1959	1960	1961	1962
Houses	146	112	148	119	137	210	149	233	121
Additions and Alterations	56	81	52	49	43	32	77	63	60
Conversions and Adaptations	6	11	6	5	5	9	11	8	18
Garages	44	101	60	81	87	241	196	238	170
Bathrooms and Drainage Installations	61	100	80	108	71	138	128	112	186
Farm Buildings	17	2	1	8	5	8	15	8	9
Sheds and Stores	6	13	9	3	5	7	12	4	15
Shops, Halls, Offices, etc.	-	3	11	4	15	9	14	18	11

The number of new units of housing erected by private enterprise or provided by the Local Authority over the same period was:

By whom erected or provided	1954	1955	1956	1957	1958	1959	1960	1961	1962
By Private Enterprise	47	90	108	115	87	127	151	155	134
By Local Authority	72	61	31	35	27	35	41	13	23

Housing (Financial Provisions) Act, 1958.

House Purchase and Housing Act, 1959.

Housing Act, 1961.

During the year 38 applications for standard grants in respect of 38 properties were received and the following amenities provided:

Fixed baths or showers	Wash basins	Hot water supplies	Water Closets	Food storage facilities	Grant paid
14	15	19	17	13	£2486

The following table gives the comparative figures for the number of Discretionary Grant applications and the amount of grants approved for each year:

Year	No. of Applications Approved	New Units of Housing Provided	No. of houses improved	Owner Occupiers	Tenanted	Total Amounts approved
1952	4	-	7	2	5	£ 508
1953	2	-	3	-	3	317
1954	14	-	17	5	12	4225
1955	48	4	65	23	46	16210
1956	55	1	60	27	34	16132
1957	60	2	72	32	42	18623
1958	33	2	34	18	18	6325
1959	74	-	82	50	32	18648
1960	69	2	74	37	39	18960
1961	59	1	68	40	29	12471
1962	55	4	64	38	30	16089
TOTALS	473	16	546	272	290	128508

There are two kinds of grant available to landlords and to owner/occupiers for improving houses erected before 1945:-

- 1. Discretionary Grant: Subject to certain conditions* up to half the estimated cost of a wide range of improvements may be paid, at the discretion of the local Council, subject to a maximum of £300. These grants are available also for the conversion of houses into flats.
- 2. Standard Grant: In some circumstances* house owners and certain leaseholders can obtain, as a right, half the cost, up to a maximum grant of £155. of providing five basic amenities:-

(a) bath or shower in a bathroom	£25.
(b) wash-hand basin	5.
(c) water closet	40.
(d) hot water supply	75.
(e) food store	10.
	<hr/>
	£155.
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* Further information is contained in a pamphlet entitled "Improve your house with a grant". Copies are available at the Council Offices.

INSPECTION AND SUPERVISION OF FOOD

Milk Supply

Under the Milk (Special Designations)(Specified Areas)(No. 2) Order, 1954, all milk sold by retail within the Droxford Rural District must be either Tuberculin Tested or Pasteurised.

Certificates issued under the Milk and Dairies Regulations, 1960:

Registration of premises as dairy -

Registration as distributor 1

Licences issued etc., under Milk Regulations, 1960:

Dealer's (pre-packed) 1

Food Hygiene Regulations, 1960.

Alterations have been made to several food premises and the opportunity has been taken to bring them up to the required standard.

Meat Inspection

Since the establishment of the Wessex Slaughterhouses Board, all meat inspection for this area is done at the Funtley Abbatoir, Fareham, except the inspection of pigs slaughtered at Knowle Mental Hospital, for consumption on Crown Property. This slaughterhouse is exempt from licensing.

There remains one knackers' yard in the district, which is licensed by the Wessex Slaughterhouses Board on receipt of recommendation from this Authority.

Food Adulteration

This section of the Food and Drugs Act, 1955, is operated by the County Council.

Details of the samples taken under the Food and Drugs Act, 1955 during the year ended 31st December, 1962:

Article	Number taken	
	Genuine	Unsatisfactory
Milk	57	-
Milk, Channel Islands	22	3
Butter	1	-
Ice Cream	1	-
Meat Products ...	4	-
Spirits	15	-
Other Foods	5	2
TOTAL	105	5

The three unsatisfactory milk samples were deficient in fat but not to any serious extent and no further action was needed.

The two unsatisfactory samples of other foods were of almond flavouring, poor in quality and containing minute traces of other flavouring agents. The matter was taken up with the manufacturers and an assurance obtained that a thorough investigation would be made to ensure that this would not occur in the future.

The above information has been obtained through the kindness of Mr. J.S. Preston, the Chief Sampling Officer of the Hampshire County Council.

RODENT CONTROL

Work on this was maintained throughout the year and block control was carried out - no new major infestations were found. The following tables give an analysis of the prevalence and control of rats and mice within the district for the twelve months ending 31st December, 1962:-

	TYPE OF PROPERTY				
	Non-Agricultural				(5) Agricultural
	(1) Local Author- -ity	(2) Dwelling Houses (inc. Council Houses)	(3) All Other (inc. Business Premises)	(4) Total of Cols. (1),(2) and (3)	
Number of properties in Local Authority's District	12	6504	604	7120	550
Total number of properties inspected as a result of notification	Nil	137	Nil	137	Nil
Number of such properties found to be infested by:-					
Common rat	Major	Nil	Nil	Nil	Nil
	Minor	Nil	137	137	Nil
House mouse	Major	Nil	Nil	Nil	Nil
	Minor	Nil	1	1	Nil
Total number of properties inspected in the course of survey under the Act	12	1689	410	2111	163
Number of properties found to be infested by:-					
Common rat	Major	Nil	Nil	Nil	Nil
	Minor	3	321	333	4
House mouse	Major	Nil	Nil	Nil	Nil
	Minor	Nil	1	1	Nil
Total number of properties otherwise inspected (e.g. when visited primarily for some other purpose)	Nil	Nil	Nil	Nil	Nil

Continued:

	TYPE OF PROPERTY				
	Non-Agricultural				(5) Agricul- tural
	(1) Local Author- -ity	(2) Dwelling Houses (inc. Council Houses)	(3) All Other (inc. Business Premises)	(4) Total of Cols. (1),(2) and (3)	
Number of such properties found to be infested by:-					
Common rat	Major	Nil	Nil	Nil	Nil
	Minor	Nil	Nil	Nil	Nil
House mouse	Major	Nil	Nil	Nil	Nil
	Minor	Nil	Nil	Nil	Nil
Total inspections carried out - including re-inspec- tions		42	2249	410	2701
Number of infested properties treated by Local Authority		3	321	9	333
Total treatments carried out - including re-treatments		34	412	54	500
Number of notices served under Sec. 4 of the Act					
(a) Treatment	Nil	Nil	Nil	Nil	Nil
(b) Structural work (i.e. Proofing)	Nil	Nil	Nil	Nil	Nil
Number of cases in which default action was taken following the issue of a notice under Sec. 4 of the Act		Nil	Nil	Nil	Nil
Legal Proceedings		Nil	Nil	Nil	Nil
Number of "Block" control schemes carried out		Nil			

SUMMARY OF INSPECTIONS MADE
AND NOTICES SERVED

BUILDING INSPECTIONS

Foundations	...	...	...	...	...	...	216
Concrete oversite	...	...	...	...	...	...	166
Damp Proof Courses	...	...	...	...	...	...	202
Intermediate	...	...	...	...	...	...	906
Drains Tested	...	...	...	...	...	...	868
Final Inspections	...	...	...	...	...	...	291
Building Inquiries Inspections	...	...	...	...	...	...	109
Short Lived Materials Section 53	...	...	...	...	...	...	-
Council House Inspections (By Public Health Inspector)	...	...	...	...	...	...	4
Town Planning Inspections	...	...	...	...	...	...	2
Sewer Connections	...	...	...	...	...	...	689

PUBLIC HEALTH ACT, 1936

Drains and Sewer Ditches controlled by the Council	...	...	...	...	...	...	7
Blocked and Insanitary Drains and Cesspools	...	...	...	...	...	...	198
Defective and Insanitary Closet Accommodation	...	...	...	...	...	...	-
Dangerous Buildings	...	...	...	...	...	...	2
Refuse Tips	...	...	...	...	...	...	26
Filthy and Verminous Premises	...	...	...	...	...	...	2
Verminous Persons (Visits)	...	...	...	...	...	...	1
Disinfestations	...	...	...	...	...	...	18
Nuisances (other than Houses) Section 92	...	...	...	...	...	...	12
Re-inspections for the purpose	...	...	...	...	...	...	23
Water Supply	...	...	...	...	...	...	18
Infectious Diseases (Visits)	...	...	...	...	...	...	47
Disinfections	...	...	...	...	...	...	-
Moveable Dwellings, Section 269	...	...	...	...	...	...	-
Other Inspections	...	...	...	...	...	...	275

FOOD AND DRUGS ACT, 1955

Carcases Inspected	...	...	...	...	...	...	66
Inspections, Other Foods	...	...	...	...	...	...	10
Food Premises, Section 13	...	...	...	...	...	...	22
Milk Distribution	...	...	...	...	...	...	7

FACTORIES ACT, 1937

Power Factories	...	...	...	...	...	...	4
Non-Power Factories	-
Outworkers	-
Other Premises	2

PETROLEUM REGULATIONS

Inspections	21
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MISCELLANEOUS

Rodent Control (by Public Health Inspector	5
Housing Applications	14
Other Visits	...	...	236
Caravan Inspections	...	...	4
Noise Abatement	...	...	-

SAMPLES TAKEN

Water	...	...	...	...	...	...	...	16
Milk	...	...	...	...	...	...	...	51
Other Samples	...	...	...	...	...	...	...	49

FACTORIES ACT, 1961

Part 1 of the Act

1. Inspections for the purpose as to health.

Premises	Number on Register	Number of		
		Inspections	Written notices	Occupiers prosecuted
(i) Factories in which Sections 1,2,3,4 and 6 are to be enforced by Local Authorities	2	-	-	-
(ii) Factories not included in (i) in which Section 7 is enforced by Local Authority	65	4	1	-
(iii) Other Premises in which Section 7 is enforced by the Local Authority (excluding out-workers' premises)	-	2	-	-
TOTALS:	67	6	1	-

2. Cases in which defects were found.

Particulars (1)	Number of cases in which defects were found		Number of cases in which prosecutions were instituted	
	Found Remedied (2)	Referred H.M. Inspector To By (4) (5)	(6)	
Ineffective drainage of floors (S.6)	-	-	-	-
Sanitary Conveniences (S.7)				
(a) Insufficient	-	-	-	-
(b) Unsuitable or defective	1	1	-	1
(c) Not separate for sexes	-	-	-	-
Other offences against the Act (not including offences relating to Out- work)	-	-	-	-
TOTALS	1	1	-	1

DISTRIBUTION

Councillors

Parish Councils

General Practitioners

Officials

(a) Central

Ministries

Agriculture, Fisheries and Food

Health

Housing and Local Government

Director of Statistics

(b) Local

Medical

County Medical Officer

Laboratory Service

Medical Officers of Health

Nursing

District Nurses

Health Visitors

Inspectors

Public Health Inspectors

Inspector of Weights and Measures

Welfare Officer

H.M. Factory Inspector

